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	085015	A. BUILDING _____ B. WING _____	C 05/23/2018

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SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from May 14, 2018 through May 23, 2018. The facility census the first day of the survey was 107 (one hundred seven). An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies based on observation and interviews.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from May 14, 2018 through May 23, 2018. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 107. The Stage 2 sample totaled 47 (forty seven) residents. Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON- Director of Nursing; ADON- Assistant Director of Nursing; RN - Registered Nurse; RD-Registered Dietitian; LPN- Licensed Practical Nurse; CNA - Certified Nurse's Aide; MD - doctor; NP - Nurse Practitioner; AP/PA-Physician Assistant, physician designee; RNAC - Registered Nurse Assessment Coordinator; UM - Unit Manager; ADLs - activities of daily living, tasks needed for	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/22/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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daily living, such as- dressing, hygiene, eating, toileting, bathing;
Airvo machine - device that provides high flows of air/oxygen mixtures;
Ambu bag - mask device used to provide air in the lungs for a patient who is not breathing or not breathing adequately;
Antipsychotic - medication to treat psychosis;
APAP - Tylenol (Acetaminophen);
Aspirin - drug to prevent blood clots;
BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15:
- 13 - 15: cognitively intact
- 08 - 12: moderately impaired
- 00 - 07: severe impairment;

Blanchable - skin loses redness/turns white when pressed with finger (better than non-blanchable);
BM - bowel movement;
BP - blood pressure,
Braden/Norton Scales - tool used to determine risk for developing pressure ulcers;
BUN (Blood Urea Nitrogen) - blood test to determine kidney function;
Call bell / call light - device used by a resident by pressing a button to signal/call staff for help need or assistance;
C-diff (Clostridium Difficile) - bacteria that attack the lining of the intestines causing diarrhea;
cm (centimeter) - a metric measurement of length; 1 centimeter = 0.39 inches;
Chloride - element used in medications and supplements and can be measured by blood test;
CMP (Comprehensive Metabolic Panel) - group of blood tests to give information on functioning of liver, kidneys, electrolytes, glucose, protein and fluid balance;
Cognitively impaired - abnormal mental processes/thinking OR mental decline including

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losing the ability to understand, talk or write;
CBC (Complete Blood Count) - blood test to determine cells in blood;
CMS - Centers for Medicare & Medicaid Services;
Cognition - mental processes or thinking;
Contact precautions - guidelines recommended by the Centers for Disease Control and Prevention for reducing the risk of transmission of certain microorganisms by direct or indirect contact;
Continence - control of bladder and bowel function;
Creatinine - creat-blood test to determine kidney function;
CVA (Cerebrovascular Accident) - stroke; poor blood flow to the brain causing cell death and loss of function such as speech, muscle strength, memory and thinking.
Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation;
e.g. - for example;
eMAR - electronic medication administration record;
EMR - electronic medical record;
Enabler - a device attached to a bed to help residents getting in and out of bed;
Enema - insertion of fluid into the bowel to cause a bowel movement;
Etc. (etcetera) - and so on;
E-Tank - large portable oxygen tank;
Extensive Assistance - resident involved in activity, staff provide weight-bearing support;
= - equals;
Glucose fingerstick - blood is obtained from sticking a needle into a resident's finger to test the blood sugar, commonly done for diabetics before meals;
Gradual dose reduction (GDR) - slowly reducing

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F 000	Continued From page 3 amount of medication while monitoring for complications; Hematocrit - blood test for anemia, ratio of red blood cells to volume of blood; Hemoglobin - blood test for anemia, amount of oxygen-carrying ability of red blood cells; Hoyer Lift - sling-type mechanical lift for residents with poor mobility; Hypertension (High Blood Pressure) - leading cause of stroke; Hypovolemic-decreaded blood flow; I&O (Intake and Output) - measuring amount of fluids drank and amount of body fluids made like urine, vomit, diarrhea; Incontinence - loss of control of bladder and/or bowel function; Frequently incontinent- 7 or more episodes of urinary incontinence but at least one episode of continent voiding; Occasionally incontinent-less than 7 episodes of incontinence; Intact - skin is unbroken; KCL tablet (potassium chloride) - medicine to prevent / treat low potassium in blood; Kg (Kilogram) - metric unit of weight; Limited Assistance - resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance; MAR - medication administration record; Meds - medications; Minimum Data Set (MDS) - assessment tool used to assess nursing home residents; Milligram (mg) - metric unit of weight, mass; Magnesium - mineral utilized for many processes in the body, including regulating muscle and nerve function, blood sugar levels, and blood pressure and making protein, bone, and DNA; Med Options - company that sees residents for mental health and psychiatric concerns;	F 000		

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Miralax - laxative solution to stimulate bowel movements;
Milk of Magnesia (MOM) - medication used to treat constipation;
mEq (milliequivalent) - unit of measurement;
Nebulizer - device to change liquid medication to a mist so it can be more easily inhaled;
O2 - oxygen;
Obturator - device to help with insertion of a tracheostomy tube;
Ombudsman - person who investigates resident complaints and helps to achieve agreement with the facility;
Offloading/Offload - positioning to remove pressure from an area;
Orthostatic-low blood pressure when going from a sitting to standing position;
PRN - as needed;
Pain Scale - rating of pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain;
% - percentage;
Physician Order Sheet (POS) - monthly report of active physician orders;
Pulse ox - measure of oxygen in blood;
po - by mouth;
Potassium - blood test to measure this electrolyte that affects functioning of nerves, muscles and heart;
post - after;
pre - before;
PRN - as needed;
PU (Pressure Ulcer) -sore area of skin that develops when the blood supply to it is cut off due to pressure;
Psychotherapeutic medications - medications for anxiety, depression, or other mental disorders;
Psychotropic (drugs) - medications capable of affecting the mind, emotions and behavior;

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F 000	Continued From page 5 Periwound - area immediately around the wound; Pneumonia - lung infection; POA (Power of Attorney) - written authorization to represent or act on another's behalf in private affairs, business, or some other legal matter; Prospective Payment System (PPS) - MDS assessment to set payment levels based on services being provided; RMS (Risk Management System) - computerized program for entering / tracking incidents including falls; Sacrum - large triangular bone at base of spine; Shear/Shearing Force - friction with reduced blood flow to the tissue under the skin from sliding down in, or being pulled across, the bed; Shiley - brand of tracheostomy device; Senna - laxative is used treat constipation; Silvasorb gel - antimicrobial wound gel; Skin prep - liquid dressing for intact skin to form protective film; SOB - shortness of breath; Stage II (2) PU - blister or shallow open sore with red/pink color; STAT - immediate; Steristrips - surgical tape strips used to close small wounds; Supervision - oversight, encouragement or cueing; Suppository - drug administered into the rectum; TAR-treatment administration record where nurses write when an ordered treatment is completed; Tracheostomy -trach- an opening made through neck into the throat to assist breathing; Tylenol - medication used to relieve pain and reduce fever; X - times; x-ray - picture of inside the body.	F 000		

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F 558	Continued From page 6	F 558		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide a reasonable accommodation of individual needs for two (R72 and R43) out of 47 sampled residents by not having the call bell within reach. Findings include: 1. The following observations were made of R72 not having the call bell in reach during the survey: 5/14/18 9:25 AM - R72 was observed in bed with call bell wrapped around side rail. Resident asked that surveyor reposition the pillow under her hip to relieve pain. Resident was asked to ring call bell and was unable to reach where it had been secured. 5/16/18 10:57 AM - Resident in bed on back, E15 (LPN) went in room and back out, call bell below side rail. 5/16/18 2:09 PM - Resident in bed and call bell was in the top drawer of the bedside table and out of reach. 5/17/18 8:54 AM - Resident in bed and call bell in the top drawer of the bedside table and out of reach.	F 558	A. R72 was discharged on 6/1/18. In-servicing completed for staff regarding placement of call bell for R43. B. Current residents have the potential to be affected. C. In-servicing for all nursing staff to be completed regarding call bells (Attachment A). Call bells should be within reach at all times. D. The Center Nurse Executive/designee will complete rounding of 10% of the resident population to ensure call bells are accessible (Attachment B). Audits will occur daily until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations and then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	7/9/18

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F 558	Continued From page 7 5/17/18 9:05 AM - Resident in bed E16 (CNA) and E15 went in room to help roommate and did not notice R72's call bell remaining in the drawer out of reach. 5/17/18 2:59 PM - Resident returned to the facility by transport staff at 2:44 PM and rang the call bell. 5/18/18 8:30 AM - In bed on back, call bell hanging out of reach below the side rail. 05/18/18 9:27 AM - In bed eating breakfast, call bell out of reach. 5/18/18 11:34 AM - In bed on back call bell out of reach E15 [LPN] observed leaving the room. 5/18/18 12:53 PM - In bed with lunch, not eating but awake, call bell remains hanging from side rail out of reach. 5/18/18 2:35 PM - In bed, call bell remains out of reach. 2. Observations / interview of R43 not having the call bell within reach during initial screening: 5/14/18 at 9:06 AM - R43 in bed and call bell on floor on window side of bed. When asked how she was today, R43 stated, "not so good." When asked if she would like to speak to her nurse, R43 stated, "yes." The Surveyor left the room and notified E13 (CNA) that R43 was asking to speak to her nurse. 5/14/18 at 9:11 AM - E13 went into R43's room and spoke to the resident, but when E13 left the	F 558		

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F 558	Continued From page 8 room the call bell was still on the floor. 5/14/18 at 9:25 AM - E14 (LPN) entered R43's room and gave the resident medications, but when E14 left the room the call bell remained on the floor. 5/14/18 at 9:45 AM - Surveyor picked up and gave R43 the call bell and R43 was able to correctly demonstrate activating it. 5/21/18 at 8:55 AM - R43 in bed with the call bell wrapped high on the enabler and out of reach of the resident. 5/21/18 at 2:15 PM - R43 in bed with the call bell still wrapped on the enabler out of reach of the resident. The facility failed to provide R72 and R43 with consistent access to the call bell. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM.	F 558		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.	F 565		7/9/18

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F 565	Continued From page 9 (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to act promptly upon the grievances and recommendations of the resident council group for 9 out of 12 months. Findings include: Record review of Resident Council minutes revealed: Eight (August, October, November and December 2017 and January, February, April, and May of 2018) out of 12 months concerns about sufficient staffing on the floors were	F 565	A. No specific residents were cited. B. Current residents have the potential to be affected. C. A copy of the Resident Council Meeting Minutes will be provided to the CED/CNE within 24 hours of the meeting for prompt follow up on any identified grievances. The CED/designee will meet with the Resident Council President within seventy two hours of the Resident Council meeting to discuss the resolution to	

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F 565	Continued From page 10 discussed. These concerns included not getting showers due to lack of a dedicated shower CNA, not helped with getting ready (cleaned up, dressed and out of bed) in time for morning activities and call bells not being answered in a timely manner. Nine (June, August, October, November and December 2017 and January, March, April and May 2018) out of 12 months concerns about staffing assistance in the dining room were discussed. These concerns included that staff were not present (or being present and not assisting) to seat residents and/or assist during meals (such as cutting up food, handing out clothing protectors). During an interview on 5/17/18 between 10:05 AM and 11:35 AM A 13 [A=anonymous resident] revealed that communicating any grievances through the chain of command had proved difficult. A 13 said "It's best to speak directly to E1 (NHA)." Common responses to grievances included: getting told to ask to use the bathroom sooner (to prevent getting toileted in the middle of an activity or when CNA is not readily available), being told there had been "cuts in the budget;" and being told to use the Stop and Watch Tool (a form to fill out when anyone had concerns about resident care) instead of speaking to any staff member. During an interview with E28 (Activities Director) on 5/8/18 at 11:29 AM, E28 explained that two individuals take minutes at each meeting, a resident and an employee from the Activities Department. The two work together to type the minutes after the meeting and the minutes are sent to the manager of each department.	F 565	identified grievances. D. The Social Services Director/designee will complete audits (Attachment C) of the monthly Resident Council Meetings minutes until 100% compliance is achieved on 5 consecutive reviews. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendation.	

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F 565	Continued From page 11 Responses to the resident council concerns are then sent to E28 and E1 for discussion at the next meeting. Findings were reviewed with E1, E2 (DON) and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM.	F 565		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		7/9/18

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F 584	Continued From page 12 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and observation it was determined that the facility failed to maintain a clean environment for residents in 2 out of 2 shower rooms and 2 out of 30 rooms surveyed. Findings include: 1. Rm 130 - Observations on 5/14/18 at 2:30 PM and 5/22/18 at 11:50 AM found a large amount of mold in the corner of the shower between tiles. 2. Rm 206 - Observations were made on 5/15/18 at 8:13 AM, 5/17/18 at 1:45 PM, 5/22/18 at 10:57 AM and 5/22/18 at 1:25 PM of a bedpan being stored uncovered on the floor of the bathroom. During an interview on 5/21/18 at 10:50 AM R56 mentioned concern about the dirty floor and curtain in the Unit 2 shower room. 3. An observation was made on 5/21/18 at 11:15 AM of the Unit 2 shower room, with a dirty floor and curtain. 4. Unit 1 shower room was also observed on 5/21/18 at 11:20 AM and 5/22/18 at 1:22 PM with a dirty curtain and floor.	F 584	A. No specific individuals cited. The shower in room 130 was cleaned on 5/23/18. The shower room floors and curtains on Unit 1 and Unit 2 were cleaned on 5/23/18. The bedpan was stored properly on 5/23/18. B. Current residents have the potential to be affected. C. Housekeeping staff will be educated regarding resident room shower cleaning, Unit 1 and Unit 2 shower room floor cleaning,and Unit 1 and Unit 2 shower room curtain cleaning (Attachment D). Nursing staff will be educated regarding storage of bedpans(Attachment E). D. Center Nurse Executive/designee to perform rounds on both units to audit bedpan storage (Attachment F). Audits will occur daily until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until 100% compliance	

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	085015	A. BUILDING _____ B. WING _____	C 05/23/2018

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F 584	Continued From page 13 Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM.	F 584	is achieved on 5 consecutive evaluations. Housekeeping Supervisor/designee will complete audits of resident shower rooms (Attachment G) and Unit 1 and Unit 2 shower rooms (Attachment H) daily until 100% is reached over 3 consecutive evaluations, then monitor weekly until 100% is achieved over 3 consecutive evaluations, then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		7/9/18

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F 623	Continued From page 14 made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related	F 623		

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F 623	Continued From page 15 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R72 and R95) out of 47 sampled residents the facility failed to provide complete transfer/discharge notice including the statement of resident's appeal rights. Findings	F 623	A. R72 was discharged from the facility on 6/1/18. R95 was discharged from the facility on 6/7/18. B. All residents transferred or discharged	

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F 623	Continued From page 16 include: The facility's Discharge and Transfer policy dated 3/21/18 documented: For unplanned, acute transfers, patient, family, and legal representative will be notified verbally followed by written notification using the Notice of Hospital Transfer or state specific transfer form...use the NOID (notice of involuntary discharge) or state specific discharge form to provide written notice...the NOD [notice of discharge] includes: reason for and effective date of transfer;, location of transfer;, explanation of right to appeal; name, address, and telephone number of Ombudsman and other parties/agencies required by state. 1. The following was reviewed in R72's clinical record: 2/18/18 - Admitted to facility. 2/21/18 - Discharged to hospital. There was no evidence that the complete transfer/discharge notice was provided. 4/4/18 - Discharged to hospital. There was no evidence that the complete transfer/discharge notice was provided. 4/28/18 - Discharged to hospital. There was no evidence that the complete transfer/discharge notice was provided. 4/18/18 (untimed) - Interview with E1 (NHA) revealed that the facility does not currently have a policy or a practice of providing transfer/discharge notice including the statement of resident's appeal rights when residents are transferred to the hospital.	F 623	have the potential to be affected. C. The Social Services Director/designee will complete the Notice of Hospital Transfer Letter (Attachment I)following a patient's transfer/discharge. The Notice of Hospital Transfer Letter includes: reason for and effective date of transfer, location of transfer, explanation of right to appeal, name, address, and telephone number of Ombudsman. A copy of the letter will be placed in the patient's medical record. D. The Center Executive Director/designee will complete audits (Attachment J) on 100% of residents transferred/discharged for the complete transfer/discharge notice until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 5 consecutive reviews. Results of audits will be presented to the monthly QAPI committee meetings for review and recommendations.	

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F 623	Continued From page 17 2. The following was reviewed in R95's clinical record: 9/28/17 - Admitted to the facility 11/5/18 - Discharged to hospital. There was no evidence that the complete transfer/discharge notice was provided. 3/23/18 - Discharged to hospital. There was no evidence that the complete transfer/discharge notice was provided. 4/22/18 - Discharged to hospital. There was no evidence that the complete transfer/discharge notice was provided. 4/18/18 (untimed) - Interview with E1 (NHA) revealed that the facility does not currently have a policy or a practice of providing transfer/discharge notice including the statement of resident's appeal rights when residents are transferred to the hospital. Findings were reviewed with E1, E2 (DON) and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM.	F 623		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment.	F 640		7/9/18

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F 640	Continued From page 18 (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved	F 640		

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F 640	Continued From page 19 by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R72 and R95) out of 47 sampled residents the facility failed to conduct and submit the correct MDS. It was found that the facility was completing an Admission MDS Assessment on all residents returning from a hospitalization. Findings include: 1. The following was reviewed in R72's clinical record: 2/18/18 - Admission to the facility. 2/21/18 - Combined Admission / 5 day Medicare and Discharge return anticipated MDS completed. Resident was admitted to the hospital. 2/26/18 - Returned to the facility. 3/5/18 - Admission / 5 day Medicare MDS completed. 4/4/18 - Admitted to hospital. 4/10/18 - Returned to facility. 4/17/18 - Admission / 5 day Medicare MDS completed. 4/28/18 - Admitted to hospital. 5/10/18 - Returned to facility. 5/17/18 - Admission / 5 day Medicare MDS completed.	F 640	A. R72 was discharged from facility on 6/1/18. R95 was discharged from facility on 6/7/18. B. All returns/readmissions have the potential to be affected. C. Review of MDS/RAI manual was completed to determine correct MDS completed upon resident returns. Education will be provided to CRC and Assistant CRC for type of MDS required upon resident return (Attachment K). D. CRC/designee will complete audits of all readmissions/returns to determine if correct MDS was completed (Attachment L). Audits will occur daily until 100% compliance is achieved, then weekly until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 640	Continued From page 20 The facility incorrectly completed and submitted to CMS a new admission MDS each time the resident returned from a hospital stay. 5/18/18 (untimed) - Interview with E6 (RNAC) revealed that she had been incorrectly completing and submitting to CMS a new Admission MDS Assessment each time a resident returns from the hospital. E6 acknowledged this was not correct and s/he would discontinue this practice. 2. The following was reviewed in R95's clinical record: 9/28/17 - Admitted to facility 10/5/17 - Admission MDS completed. 11/5/18 - Discharge to hospital. 11/7/17 - Returned to facility. 11/14/17 - Admission MDS completed. 3/23/18 - Discharged to hospital. 3/29/18 - Returned to facility. 4/5/18 - Admission / Medicare 5 day assessment completed. 4/22/18 - Discharged to hospital. 4/28/18 - Returned to facility. 5/5/18 - Admission / 5 day Medicare Assessment completed.	F 640		

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F 640	Continued From page 21 5/18/18 (untimed) - Interview with E6 (RNAC) revealed that she had been incorrectly completing and submitting to CMS a new admission MDS Assessment each time a resident returns from the hospital. E6 acknowledged this was not correct and s/he would discontinue this practice. Findings were reviewed with E1(NHA), E2 (DON) and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM.	F 640		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		7/9/18

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F 655	Continued From page 22 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R72, R22, R64 and R102) out of 47 sampled residents the facility failed to ensure the summary of the base line care plan was provided to the resident and/or responsible party. Findings include: 1. R72 was admitted on 2/18/18. No evidence that the base line care plan summary was found during review of the record. 2. R22 was admitted on 2/21/18. No evidence that the base line care plan summary was found during review of the record. 3. R64 was admitted on 11/30/17. No evidence that the base line care plan summary was found during review of the record. 4. R102 was admitted on 4/24/18. No evidence	F 655	A. R72 was discharged on 6/1/18. R22 had a care plan review on 6/20/18. R64 had a care plan review on 5/7/18. R102 had a care plan review on 6/13/18. B. All new admissions have the potential to be affected. C. Review of federal regulation 483.21 occurred to determine the facility's course of action. Process developed for social services to deliver a communication folder to the room and review the initial care plan and orders when initial post admission meeting occurs. The social worker/designee will document a note in the clinical record that the baseline care plan was provided to the patient and/or the resident representative. The communication folder will contain a	

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F 655	Continued From page 23 that the base line care plan summary was found during review of the record. 5/18/18 10:40 AM - Interview with E2 (DON) revealed that the facility had not initiated the practice of providing the base line care plan summary to residents and/or their responsible party. E2 revealed that the facility had been exploring different formats to present the information but had not decided on how they plan to implement this requirement. Findings were reviewed with E1(NHA), E2 and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM.	F 655	summary of the baseline care plan and initial orders. The communication folder will remain in the resident's room for resident and responsible party reference. Social services and nursing staff will be educated regarding new process(Attachments A and M). D. Social Services/designee will complete audits of post admissions meeting to determine if communication folder is delivered and reviewed with resident/responsible party and pertinent information for care plan and initial orders are present (Attachment N). Audits will continue until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations and then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		7/9/18

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F 657	Continued From page 24 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to revise the care plan for two (R38 and R39) out of 47 sampled residents to reflect current fall prevention needs and respiratory status. Findings include: 1. Cross refer F689, Example 2. The following was reviewed in R38's record: 7/31/17 - Care plan for Resident at risk for falls: immobility and poor safety awareness with approaches that included: -low bed (added 5/6/18), get in and out of bed with 2 assist, provide verbal cues for safety and sequencing when needed (added 5/6/18) 9/17/17 3:15 AM - RMS report of fall from low bed.	F 657	A. R38 has had revisions to fall care plan to reflect current interventions. R39 was discharged from facility on 6/3/18. B. Current residents have the potential to be affected. C. Audit of all fall care plans completed 6/20/18. Patients with respiratory diagnosis or oxygen use have had care plans audited for use of respiratory care plan - completed 6/20/18. Unit managers to use Fall RCA for tracking of new interventions post fall (Attachment O). Nursing leadership team to be educated on use of Fall RCA (Attachment P). D. The Center Nurse Executive/designee will complete audits of 10% of the resident population to determine if resident care	

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F 657	Continued From page 25 3/14/18 - Quarterly MDS Assessment documented R38 was cognitively impaired, required extensive assistance with bed mobility, transfer and toileting, frequently incontinent of bladder, no toileting plan and no falls. 5/2/18 3:00 PM - RMS reported "Patient found on floor, next to her bed". Corrective action was to continue care plan, maintain low bed, frequent rounding, verbal cueing for safety as indicated. There was no mention of the fall mat that was put in place. 5/16/18 9:08 AM - Resident noted to be in bed with eyes closed and a fall mat on right side of bed. 5/22/18 3:13 PM - Interview with E15 (LPN) revealed the fall mat was added 5/2/18 after the fall. E15 also confirmed that the approach to use a fall mat was not included on the CNA task list or the CNA Kardex. 5/22/18 3:40 PM - Interview with E2 (DON) when asked about the fall mat not being an approach prior to the 5/2/18 fall and once it was initiated it was not added to the care plan, CNA tasks/Kardex or the physician orders. There was no further information shared. 2. Review of R39's clinical record revealed: 7/26/17 - Physicians' orders included oxygen continuously after hospitalization for respiratory failure. Current Care plan did not include anything related to continuous use of oxygen.	F 657	plans include appropriate respiratory care plan and fall care plan with interventions (Attachment Q). Audits will occur daily until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations and then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality of Assurance Performance Improvement Committee for review and recommendations.	

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F 657	Continued From page 26 During an interview with E2 (DON) on 05/17/18 at 1:05 PM it was confirmed that R39's care plan did not address respiratory status and the need for continuous oxygen and that E2 would add it. Findings were reviewed with E1(NHA), E2 and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM.	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of other facility documentation it was determined that the facility failed to provide care and services in accordance with professional standards of practice for five (R45, R96, R255, R17 and R56) out of 47 sampled residents. For R45 the bowel protocol was not implemented and the resident repeatedly went with no bowel movements, the longest time frame was 10 days (31 shifts). For R96, the facility did not obtain blood tests after resident refusal and had no process for reattempting specimen collection. The facility failed to obtain weekly weights as ordered for R255. The facility failed to ensure that R17's medication was administered	F 684	A. R45's bowel protocol reviewed for complete orders and need for additional stool softener. R96 had had all laboratory testing completed. F255 was discharged 2/17/18. R17 had potassium dose adjusted after laboratory analysis of potassium level. R56 skin tear treatment to the right leg was discontinued as area is healed. Appropriate treatment to skin tear on left leg ordered. B. Current residents have the potential to be affected. C. Current daily bowel protocol audit tool	7/9/18

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F 684	Continued From page 27 according to physician's orders. For R56, the facility provided wound care treatment without a physician order, but did not perform wound care to the site that was ordered. Findings include: 1. Review of R45's clinical record revealed: 12/21/15 - Care plan problem for constipation included interventions: Monitor and record bowel movements; Provide bowel regimen, utilize pharmacological agents as appropriate like stool softeners, laxatives, etc and document effectiveness. Physicians' orders included several medications for constipation: 8/11/16 - Senna 2 tablets daily. 8/15/16 - Milk of Magnesia (MOM) PRN if no BM in 3 days. 8/15/16 - Suppository rectally PRN if no result within 24 hours from MOM. 8/15/16 - Enema PRN if no result within 24 hours from suppository. 8/29/16 - Miralax every 24 hours PRN. 8/14/17 - Miralax daily (scheduled). February - May 2018 - CNA flowsheets for BMs found 5 instances when the bowel protocol should have been implemented. Review of eMARS revealed: A. 2/2/18: medium BM on evenings and no BM until 2/13/18. . . 10 days (31 shifts) with no BM. - Did not receive PRN MOM or Miralax on February 6, after 3 days with no BM. - MOM given on February 7 (8:30 AM), medication not effective and no suppository administered. - 2/8/18 BM Audit sheet (daily report of residents who have not had a BM in 3 days or longer)	F 684	evaluated for effectiveness. Changes made to audit tool to capture interventions and assessments related to potential constipation each shift (Attachment R). Current procedure for refusal of blood draws reviewed. Procedure changed to address repeat attempts and notification of refusal for any specimen collection. Weekly weights placed as an order on the MAR to facilitate obtaining weights per policy. Medication administration policy reviewed. Nursing staff to be educated on new bowel protocol audit tool, procedure for refusal of blood draws/specimen collection, medication administration and review of weight policy (Attachment A). Nursing staff will be educated on skin tear documentation and treatment orders Attachment E). D. The Center Nurse Executive/designee will complete audits of all applicable residents for bowel protocol completion (Attachment S) refusal of specimen collection procedure (Attachment T) and verify treatment orders match the skin integrity report for skin tears (Attachment U). The CNE/designee will also audit 10% of the resident population for compliance with weight policy (Attachment V) and medications left at bedside (Attachments W). Audits will occur daily until 100% compliance is achieved x 3 consecutive evaluations, then weekly until 100% compliance is achieved x 3 consecutive evaluations and then monthly until 100% compliance is achieved x 5 consecutive evaluations. Results of audits will be presented to the Quality	

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F 684	Continued From page 28 documented resident refused MOM. - Resident on the 2/9/18 BM Audit sheet with no notation by the nurse. - 2/10/18 BM Audit sheet indicated resident received MOM (was not documented on the eMAR). Medication not effective. - Resident on the 2/11/18 BM Audit sheet with no notation by the nurse. - 2/12/18 BM Audit sheet reflected resident would take MOM at bedtime. MOM given at 8:51 PM with large BM on days 2/13/18, 10 days after prior BM. B. 2/19/18: medium BM on evenings - Did not receive PRN MOM or Miralax on February 23, after 3 days with no BM. - Did have BM on nights after midnight on 2/24/18. C. 4/17/17: medium BM on days and no BM until 4/26/18 days . . . 8 days (24 shifts) with no BM. - Did not receive PRN MOM or Miralax on April 21, three days after no BM. - BM Audit sheets not provided from this time frame and no other PRN medication was administered for constipation. D. 4/29/18: medium BM on days and no BM until 5/6/18 days . . . 6 days (20 shifts) with no BM. - Did not receive PRN MOM or Miralax on May 3, after 3 days with no BM. - BM Audit sheets not provided from this time frame. - MOM given May 6 (1:06 PM) and produced a BM 6 days after the previous BM. E. 5/12/18: medium BM on days and no BM until 5/18/18 days . . 5 days (15 shifts) with no BM. - 5/16/18 BM Audit sheet documented resident	F 684	Assurance Performance Improvement Committee for review and recommendations.	

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F 684	Continued From page 29 wanted to wait until bedtime to take. PRN MOM or Miralax not given at bedtime, after 3 days with no BM. - Medication not effective and no suppository administered. - BM Audit sheets not provided from this time frame and no other PRN medication was administered for constipation. During an interview with E2 (DON) on 5/17/18 around 11:24 AM E2 confirmed that small bowel movements do not count when determining when the bowel protocol would be implemented. E2 provided copies of BM Audit sheets. 2. Review of R96's clinical record revealed: 5/25/16 - Admitted to the facility with multiple diagnoses including dementia. March, 2018 - Laboratory [labs] tests scheduled to be obtained, but no results were available in the record. During an interview with E2 (DON) on 5/17/18 around 2:50 PM E2 confirmed the facility had no process for re-attempting to obtain laboratory testing when the resident initially refused. During a follow-up interview with E2 on 5/17/18 at 4:00 PM, E2 stated that R96's labs were due on 3/5/18 but showed the Lab Test Log Tracking Form that indicated "resident refused." Seven different lab tests were ordered but not performed. E2 stated that s/he entered an order for each of the blood tests into the computer for the next morning, 5/18/18. Observation on 5/18/18 around 9:30 AM	F 684		

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F 684	Continued From page 30 discovered the resident permitted the blood specimen to be obtained as evidenced by having a bandage on the arm where the blood was drawn. During an interview with E2 on 5/18/18 around 11:56 AM, blood test results were provided to the surveyor (normal range in parenthesis). The blood level of a seizure medication was slightly elevated at 20.5 (normal 10-20) and the mood stabilizer was low at 22.7 (normal 50-100). There was a delay in lab testing since the facility had no process for re-attempting collection of a blood specimen when a resident initially refused. Tests scheduled for 3/5/18 were not completed until 5/18/18 after brought to the facility's attention by the surveyor. Cross Refer F692, example 1 3. Review of R255's clinical record revealed: 1/3/18 - Admission to facility as short stay resident for rehabilitation after hospitalization. 1/3/18 - Physicians' orders included weekly weight for four weeks. Review of weights (in pounds) found: 1/3/18: 150.2 1/10/18: 149 on 1/7/18 1/17/18: not done 1/24/18: 146.4 on 1/21/18 1/31/18: not done 2/7/18: 148.3 on 2/5/18 During an interview with E18 (Corporate Nurse) on 5/22/18 around 11:26 AM E18 confirmed that all of the weekly admission weights were not	F 684		

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F 684	Continued From page 31	F 684		

obtained.
4. Review of R17's clinical record revealed:

11/19/16 - Physicians' order included two potassium chloride (KCL) pills to be given one time a day.

4/2/18 - Lab results showed both potassium and chloride blood levels were within normal range.

5/14/18 4:30 PM - Observation: large white KCL tablet on R17's over-the-bed table.

During an interview with R17 on 5/14/18 at 4:30 PM when asked about the tablet, R17 stated s/he tried to tell the doctor and nurses that s/he "only wanted to take one tablet a day, but they would not listen." For the past 7-10 days R17 had been swallowing only one tablet the nurses gave in the morning, R17 would removed the other tablet out of the medicine cup, wrap it in a cough drop wrapper and would throw it into the trash can. When asked if the nurses noticed that s/he did not take one of the tablets, R17 said "No, they did not notice" since s/he took the tablet out of the cup after the nurse left the room. R17 stated s/he is a biologist and saw on the television that too much KCL could be very harmful which is why the resident only wants to take one KCL tablet a day. The surveyor suggested to R17 that s/he discuss this with her doctor and nurses. R17 responded, "No. I already tried to say something and it did not change. So, I am not going to stir the pot anymore."

5/14/18 - eMAR documented that R17 took two KCL tablets at 9:00 AM even though one tablet was on the bedside table.

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F 684	Continued From page 32 During an interview with R17 on 5/17/18 at 2:00 PM R17 stated s/he only took one tablet today and that the other was wrapped in a cough drop wrapper in the trash can. 5/17/18 - eMAR documentation indicated R17 took two 2 KCL tablets at 9:00 AM even though the resident stated one tablet was discarded. During an interview with E3 (RN, UM) on 5/17/18 at 2:10 PM to review the aforementioned information, E3 confirmed that a KCL tablet was inside a cough drop wrapper in R17's trash can. 5/17/18 at 4:16 PM - Nursing Note: Resident expressed her concern over potassium dosing. Stated "my heart is fine. I saw a program on TV that says too much potassium is dangerous". Discussed importance of potassium with cardiac patients. Provider aware and labs ordered. Will discuss again with patient after lab results obtained. 5/17/18 Nurse Practitioner Note - Nursing had advised me yesterday that R17 was found to only be taking "one" potassium tablet. Since the potassium level was within normal limits, the NP reduced the resident's potassium to one tablet daily. 5. Review of R56's clinical record revealed: 4/20/18 - Physician's order: Cleanse skin tear to posterior right leg with wound cleanser, skin prep peri [around] wound, apply Silvasorb gel [wound treatment] to open area, cover with dry dressing, change daily and PRN. 5/17/18 - Skin Integrity Report in unit's Wound	F 684		

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F 684	Continued From page 33 Care Book: Right lateral [side] leg skin tear wound due to be assessed. 5/17/18 1:45 PM - Observation/Interview: E11 (LPN, Charge Nurse) changed dressing on left lower leg. When asked why s/he changed dressing on left leg instead of right leg. E11 stated she was going by what is on the TAR (Treatment Administration Record). 5/17/18 - TAR: Cleanse skin tear to posterior [back] right leg with wound cleanser, skin prep periwound, apply Silvasorb gel to open area, cover with dry dressing, change daily and prn every day shift. The TAR did not include treatment for a left leg wound. 5/17/18 7:00 AM - 3:00 PM - TAR: E11 signed that she performed wound care on R56's posterior right leg wound (not the left leg wound as observed). There was no order for left leg wound care that was performed by E11 and wound care was not performed on the right leg. 5/18/18 8:30 AM - Interview: E2 (DON) notified of above discrepancies. Findings were reviewed with E1 (NHA), E2 and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		7/9/18

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F 686	Continued From page 34 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for two (R77 and R78) out of 8 sampled residents investigated for pressure ulcers and limited ROM/positioning the facility failed to ensure residents with pressure ulcers received the treatment and services to prevent more pressure ulcers from developing. Findings include: 1. The following was reviewed in R77's clinical record: 7/30/13 (revised 4/28/18) - Care plan for Resident is at risk for skin breakdown as evidence by Braden risk assessment and incontinence. Approaches included: -barrier cream, redistribution surfaces, turn and reposition, Norton/Braden per policy, weekly skin assessment. 3/26/16 - Resident developed a Stage 2 pressure ulcer to sacrum. 3/26/18 - Care plan for Resident has actual skin breakdown. Approaches included: -encourage to consume fluids, evaluate wound area daily, monitor pain, provide treatment, weekly wound assessment.	F 686	A. R77 was discharged from facility on 5/18/18. R78 continues to have a task and care plan intervention to turn and reposition Q2 hours. B. Current residents have the potential to be affected. C. Nursing staff will be educated regarding offloading heels and reporting/documenting refusal of turning and repositioning Q2 hours (Attachment A). D The Center Nurse Executive/designee will complete audits on 10% of the resident population to monitor offloading of heels and turning and repositioning Q2 hours (Attachment X). Audits will occur daily until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality Assurance and Performance Improvement Committee for review and	

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F 686	Continued From page 35 3/26/18 (originated 6/3/14) - CNA Task Preventative skin care included pressure relieving device for bed, chair, float heels when in bed (added 3/26/18), turn and/or reposition and check skin every 2 hours or as specified by plan of care. 4/28/18 - Quarterly MDS Assessment documented R77 required extensive assistance with bed mobility. Observations during the survey included: 5/16/18 at 9:10 AM, 11:02 AM, 12:54 PM and 1:54 PM - Resident in bed on back. 5/16/18 at 1:54 PM - Treatment observation with E15 (LPN) and E8 (CNA). E15 stated that resident is on side-to-side turns. At the end of the treatment R77 was on his back and heels were not off-loaded. There was no order, care plan or CNA task for side-to-side turns. 5/17/18 at 11:29 AM - In bed tilted slightly to left with pillow under calves but heels were not off-loaded. 5/17/18 at 2:21 PM - In bed lying on the back with a pillow under calves but heels touching the bed. 5/17/18 at 4:20 PM - In bed on back, pillow under legs but heels not elevated. 5/18/18 at 8:25 AM - In bed on back being fed breakfast. Right heel on mattress, left heel leaning on right heel, pillow under calf but not	F 686	recommendations.	

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F 686	Continued From page 36 off-loading heels. 5/18/18 at 12:47 PM - In bed on back and heels not off-loaded. 5/18/18 at 1:45 PM and 2:36 PM - In bed on back, pillow under calves but no off loading of heels. 5/22/18 4:30 PM - Interview with E1 (NHA) and E2 (DON), reviewed the above observations. 2. Review of R78's clinical record revealed: 12/30/16 - Admitted to the facility with multiple diagnoses including brain bleed and left sided weakness. 12/30/16 - Care plan problem for Risk for development of skin breakdown as evidenced by refusal to turn and reposition, poor nutritional intake and limited mobility. Interventions included encourage turn and/or reposition and skin checks every 2 hours or as specified by the plan of care. 2/28/17 - Care plan problem for actual skin breakdown related to informed refusal to aspects of care (T&R) and nutritional concerns - poor intake. Resident has a Stage 2 PU on right buttocks. Interventions included encourage turn and/or repositioning and check skin every 2 hours or as specified by plan of care added 8/7/17. 4/29/18 - Quarterly MDS Assessment documented R78 required extensive assistance with bed mobility. Observations of resident lying in bed on the back without seeing staff attempting, or offering /	F 686		

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F 686	Continued From page 37 encouraging, R78 to turn or reposition: 5/16/18 - 8:53 AM, 10:05 AM, 11:50 AM, 1:15 PM and 3:22 PM. 5/17/18 - 8:30 AM, 11:30 AM, 1:55 PM and 3:55 PM. 5/18/18 - 8:20 AM, 9:30 AM, 10:18 AM, 11:55 AM, 1:38 PM and 3:30 PM. 5/21/18 (around 10:10 AM) - Resident seen repositioned in bed. During an interview with R78 on 5/21/18 at 8:56 AM when asked if s/he can turn, R78 stated "they change me." When asked if s/he needed help to turn or could s/he turn self, R78 looked confused and had no response. During an interview with E2 (DON) on 5/21/18 at 11:40 AM to discuss R78's observed lack of repositioning outside of today, E2 stated that resident "hates it and will wiggle back." That's why "we can't get her to heal" and she is on a low air loss mattress. This finding was reviewed with E1 (NHA), E2 and E3 (ADON) on 5/23/18 at 11:45 AM.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		7/9/18

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F 689	Continued From page 38 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for three (R3, R38 and R99) out of 47 sampled resident the facility failed to ensure the environment was free of an accident hazard and the facility failed to ensure post fall assessments were conducted in a manner that ensured the root cause of falls could be determined and approaches initiated to prevent additional falls and/or injury. For R99 the facility also failed to provide transfer assistance according to the plan of care. In addition the bathroom in one (room 228) out of 30 rooms surveyed had a loose grab bar. Findings include: 1. The following was reviewed in R3's clinical record: 4/28/14 (last reviewed 4/28/18) - Care plan for Resident at risk for falls: related to history of falls and CVA. A goal for the resident was will have no falls with injury. Interventions included: - assist resident getting in and out of bed with 1; - place call light in reach at all times; - remind resident to use call light when attempting to ambulate or transfer. 5/1/18 - Care plan evaluation - fall precautions in place, resident toilets self at times ambulates with quad [4 pronged] cane. Encouraged to ring call bell for assistance. 5/10/10 - Quarterly MDS Assessment documented the resident was cognitively intact with a BIMS of 15, required extensive assistance with one person physical assist for transfer, walking in room and toileting, history of one	F 689	A. An interview was conducted with R3 by the ADON on 5/17/18. Potential verbal abuse allegation submitted to the State on 5/17/18. R38's fall care plan was revised with updated interventions. R99 was discharged from the facility on 5/12/18. Grab bar in room 228 repaired. B. Current residents have the potential to be affected. C. The nursing leadership team evaluated current fall investigation practices. A Fall RCA form was developed to summarize resident/staff interviews and care plan changes/additions (Attachment O). RCA of fall for R99 completed and identified that the Kardex may not always have information for transfer status available. Nursing staff to be educated to review placement of interventions and accessing the Kardex (Attachment E). Maintenance director completed facility audit of all grab bars. D. Center Nurse Executive/designee will audit all Fall RCA forms for completion and care plan changes/additions (Attachment Y). Maintenance Director will audit 10% of rooms to ensure securely fastened grab bars (Attachment Z). Audits will occur daily until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations,	

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F 689	Continued From page 39 recent fall with no injury, occasionally incontinent of bladder and not on a toileting plan. 5/15/18 7:25 PM - RMS report documented "Resident transported self to her bathroom, and fell in entrance of bathroom door. Resident was assessed, and Hoyer lifted onto her bed. Left outer forearm was cleansed and steri strips applied. Left hand tear was cleansed and steri strips applied". The report documented the resident hit her head and neurological evaluation was completed. Activity during incident "rising from chair/wheelchair," fall related to ambulation status "unsteady gait", and only occasionally incontinent. The RMS documented a change of condition was initiated, a fall evaluation was completed per policy, CNA Kardex [instructions] updated as needed and fall added to 24 hour report. The root cause conclusion was "poor safety awareness" and corrective action was "x-ray right wrist for complaint of pain, comfy roll to hand for comfort and therapy screening/evaluation". 5/15/18 9:13 PM - Change of condition note - Resident transported self to the bathroom, and fell in entrance of her bathroom. Skin tear to left outer arm and left hand cleansed, steri strips applied. The RMS report contained no interviews with the resident or staff in the area during the fall. The report was lacking evidence that a complete root cause analysis was conducted. 5/16/18 8:55 AM - Interview with resident revealed R3 had a fall last night and a skin tear with loose steri strips was noted to be bleeding in knuckle area. The resident also had a dressing to	F 689	and then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 689	Continued From page 40 the left forearm. R3 told the surveyor s/he fell last night, and stated an aide put her on toilet and left her to use the call bell when R3 was done. R3 stated she rang the cal light and no one came, R3 yelled out and no one came. R3 went on to add that s/he was not wearing oxygen because the tubing did not reach that far and the resident was getting anxious about not having oxygen. The resident attempted to get him/herself back to bed and fell. R3 added that, after the fall, the aide argued with the resident about not waiting for assistance and the aide stated s/he had 13 residents to care for and had been in another residents room when R3 was calling for help. 5/16/18 3:48 PM - Interview with E20 (LPN) revealed that it was E20's understanding the resident was in the bathroom at the time of the fall and was trying to get up by him/herself. E20 stated that R3 did not tell her she hit her head but neuro checks were started anyway. This interview was not consistent with the RMS report. 5/16/18 4:07 PM - Interview with E22 (RN) revealed R3 was found at the entrance to the bathroom and it "looked like" she was going to the bathroom. She said the resident said her head hurt but she did not know if she hit her head so she was put on neuro checks. 5/17/18 4:25 PM - An interview with R3's responsible party revealed that she was called by staff and told about the fall. She then called R3 on the telephone in her room to check on her. She stated that she could hear the aide (E21) yelling and talking bad to the resident, she stated it sounded like she was trying to convince her to change her story and was telling her it was her (R3's) fault she fell because she should have	F 689		

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F 689	Continued From page 41 called for assistance. She heard R3 tell E21 that she did call and no one came. E21 replied that she had 13 residents and was changing someone else. 5/17/18 4:40 PM - E2 (DON) and E4 (RN, UM) were made aware of the above interview. E2 revealed that E21 walked off the job yesterday and her phone has been disconnected. E2 stated that there were no interview or witness statements from the fall because it was unwitnessed. E2 went on to state that the nurse should have done a full assessment including an interview with the resident about what happened. The facility failed to have an accurate accounting of an unwitnessed fall when the facility failed to thoroughly investigate and failed to do a root cause analysis of contributing factors. The failure prevented the facility from developing approaches to prevent further falls from occurring and minimizing injury when falls do occur. 2. The following was reviewed in R38's clinical record: 7/31/17 - Care plan for Resident at risk for falls: immobility and poor safety awareness with approaches that included: -low bed (added 5/6/18), get in and out of bed with 2 assist, provide verbal cues for safety and sequencing when needed (added 5/6/18) 8/15/17 - Care plan for Resident is incontinent of urine with potential for improved control or management of urinary elimination dementia -encourage resident to use toilet upon awakening, after meals, nightly and PRN	F 689		

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F 689	Continued From page 42 Fall Risk Assessments (based on MDS data) 8/7/17 - 14 high risk 9/11/17 - 4 (no risk level noted) This assessment was inaccurate due to fall assessment fields being grayed out due to not being a full comprehensive MDS assessment. 9/17/17 3:15 AM - RMS report of fall "Patient was found on floor by CNA. Patient was sitting against the doorway calling out. Bed was in lowest position. Alarm was found on floor, Patient had detached the alarm. Patient stated that she is not having any pain. When assessed no [sic] injured. Non-skid shoes were on. Call bell was in reach". 12/12/17 - Fall Risk Assessment - 12 high risk 3/14/18 - Quarterly MDS documented R38 was cognitively impaired, required extensive assistance with bed mobility, transfer and toileting, frequently incontinent of bladder, no toileting plan and no falls. 3/24/18 - Fall Risk Assessment 11 (no level noted) 5/2/18 3:00 PM - RMS report "Patient found on floor, next to her bed". The resident sustained a skin tear, cut/laceration, and head injury (bump and bruising to forehead/face). Preventative measures in place were call bell, staff assist with transfers, personal items in reach and monitor/frequent toileting. Interventions added were verbal cueing for safety and redirection (resident is cognitively impaired) and bed in lowest position (already listed as intervention), resident not on toileting plan but will ask for bedpan and is frequently toileted / incontinence care given as indicated. Root cause was listed	F 689		

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F 689	Continued From page 43 as: patient confusion, difficulty to redirect and poor safety awareness remain factors in risk of fall. Corrective action was to continue care plan, maintain low bed, frequent rounding, verbal cueing for safety as indicated. There was no evidence that a thorough investigation was conducted including interviewing staff caring for for the resident prior to the fall. 5/22/18 9:56 AM - Interview with E4 (RN, UM) and E15 (LPN) revealed the resident was getting out of bed at time of 5/2/18 fall and confirmed there was no fall mat in use at the time. The resident is incontinent with no toileting plan because the resident has become difficult to transfer. E4 stated that because the fall was unwitnessed there were probably no staff statements conducted. The surveyor pointed out that the RMS report does not say where the resident was before the fall (wheelchair or bed). 5/22/18 3:13 PM - Interview with E15 and E20 (LPN) who were both working at 3:00 PM on 5/2/18 confirmed a fall mat was not an approach in place when the fall occurred and that it was put in place after the resident returned from being checked out at the emergency room. E15 confirmed that the approach to use a fall mat was not on the task or the CNA Kardex. 05/22/18 3:40 PM - Interview with E2 (DON) when asked about the fall mat not being an approach prior to the 5/2/18 fall and once it was initiated it was not added to the care plan, CNA tasks/Kardex or the physician orders. There was no further information shared. 3. Review of R99's clinical record revealed:	F 689		

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F 689	Continued From page 44 4/23/18 - Admission to facility with multiple diagnoses including dementia, difficulty walking and repeated falls. 4/23/18 Care plan problems: - ADLs (activities of daily living): included the intervention that R99 needed limited assist of 1 staff for transfer. - Fall Risk: interventions included monitor vital signs including orthostatic blood pressure as needed and report to MD as indicated; Remind resident to use call light when attempting to ambulate or transfer; When resident in bed place all necessary personal items within reach. 4/30/18 - Admission MDS Assessment indicated R99 was severely cognitively impaired, required extensive assistance with transfer, toileting, was not steady with walking or transitioning between positions (sitting/standing) and needed supervision when walking in the room. 5/4/18 - Care plan problem for urinary incontinence with potential for improved control or management of urinary elimination included interventions: encourage resident to use toilet upon awakening, after meals, nightly and PRN; Instruct resident on task prior to starting; Offer/assist with urinal / commode as requested / needed; Provide access to bathroom. 5/5/18 - 5/5/18 - Nursing Progress Notes documented R99 continued to get out of bed unassisted despite constant reminders. Can be unsteady on feet. 5/7/18 - Nursing Progress Notes documented R99 was able to sit on side of bed and use the	F 689		

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F 689	Continued From page 45 urinal. 5/7/18 - 14-day PPS [prospective payment system] MDS Assessment documented R99 needed only limited assistance with transfer but continued to be unsteady with walking / transitioning between positions and needed supervision for walking in the room. 5/9/18 - Nursing Progress Note documented R99 needed the assist of one person to get out of bed to the wheelchair. 5/10/18 - Nursing Progress Note documented the resident continued to get out of bed to wheelchair on his/her own despite constant reminders. Can be unsteady on his feet and has history of falls. 5/12/18 (3:35 AM) - Nursing Progress Note documented R99 asked for scissors to cut his/her pants but was able to be redirected. 5/12/18 (2:47 PM) - Nursing Progress Note included resident complained of not feeling well and felt dizzy. BP 176/81, Pulse 60, Glucose fingerstick 96. Resident attempted to transfer self to bathroom and fell. Found lying on right side. R99 stated s/he hit head and was returned to bed with a mechanical lift. Complained neck and shoulder pain. NP and POA informed. Sent to emergency department for evaluation. Review of fall investigation conducted by the facility included statements by E24 (CNA), E25 (RN) and housekeeper who found resident on the floor. The incident report documented the resident "attempted to go to the bathroom," fell on right side, complained of right shoulder / neck pain. The investigation did not include when the	F 689		

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F 689	Continued From page 46	F 689		

last time R99 was toileted. The incident report documented R99 was not on a toileting plan, which conflicts with the care plan of encouraging toileting upon awakening, after meals, nightly and PRN. Facility identified the root cause of the fall being poor safety awareness and some confusion. R25's statement included the resident told the paramedics that s/he fell because E24 said to "Do it himself." E25 wrote that E24 "admitted to telling him this but stated she did not know he was dizzy."

During an interview with E25 on 5/22/18 at 2:10 PM E25 confirmed the written statement was accurate. E25 said R99 got pale and weak in physical therapy and was dizzy after therapy. When asked to explain the statement about the CNA, E25 informed the surveyor that E24 told E25 "on several occasions" after R99 fell that s/he told the resident to get up.

E24's written statement included that the CNA answered the call light and R99 said s/he rang the bell and wanted to use the bathroom. "I asked him to sit up with me so we can go to the bathroom, he replied he could not get up. I walked out of the room to answer another light."

During an interview with E24 on 5/22/18 at 2:28 PM E24 confirmed the written statement was accurate. E24 said she told R99 "Come on and get up. If I knew he was dizzy I would have had him use the urinal or something."

During an interview with R99's daughter on 5/23/18 around 10:30 AM revealed that the fall resulted in R99 having with swelling on the top of a foot, a leg laceration and a facial bruise.
4. The bathroom in room 228 was observed on

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F 689	Continued From page 47 5/14/18 at 2:40 PM and 5/18/18 at 11:50 AM having a loose grab bar next to the toilet. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/23/18 at 11:45 AM.	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		7/9/18

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F 690	Continued From page 48 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R95) out of 47 sampled residents the facility failed to ensure the resident received the services and assistance to maintain bladder continence. R95 was admitted to the facility continent of bladder. When the resident was assessed as declining to occasionally incontinent and later frequently incontinent of bladder, the facility failed to thoroughly assess and develop interventions to restore bladder function. This lack of assessment and failure to implement interventions resulted in harm to R95. Findings include: The facility's Continence Management policy dated 6/1/96 and last revised 3/1/18 documented: A urinary incontinence assessment and/or bowel incontinence assessment and the Three-Day Continence Management Diary will be completed if the patient is incontinent upon admission or re-admission and with a change in condition or change in continence status. Continence status will be reviewed quarterly and with significant change as part of the nursing assessment. The following was reviewed in R95's clinical record: 9/28/17 - Admitted to the facility. 10/5/17 - Admission MDS documented R95 was cognitively intact (BIMS 15), required supervision with one person physical assist for toileting,	F 690	A. R95 was discharged from the facility on 6/7/18. B. Current residents have the potential to be affected. C. RCA for R95's changes in urinary continence was completed on 5/24/18. Continence Management Policy reviewed to determine appropriate course of action. The nurse completing the MDS, will notify the CNE and Nurse Unit Managers of any resident with a decline in urinary incontinence from the previous MDS and will schedule a Urinary Incontinence Evaluation. The Unit Managers will verify that the 3 day diary is initiated, completed, and the Nursing Intervention is completed with a revision of the care plan accordingly. Nursing staff to be educated about completion of urinary continence assessments and 3-day diary (Attachment A). D. Center Nurse Executive/designee will complete audits of the MDS response analyzer to identify residents with a change in urinary incontinence and subsequent scheduling of the urinary continence evaluation, initiation of the 3-day continence diary and recommended changes to care plans and interventions (Attachment AA). Audits will occur daily	

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F 690	Continued From page 49 continent of bladder and no toileting plan. 11/5/18 - 11/7/17 - Admitted to hospital. 11/14/17 - Medicare MDS documented a decline in cognition to a BIMS of 12, independent in toileting with supervision and continent of bladder. 1/27/18 - Urinary Incontinence Evaluation provided no conclusion or plan for R95. 2/14/18 - Quarterly MDS documented a BIMS of 14, independent in toileting, continent of bladder and no toileting plan. March 2018 - Review of CNA documentation in the EMR revealed that R95 was incontinent of bladder 4 out of 75 opportunities or 5% of the time. 3/23/18 - 3/29/18 - Admitted to hospital. 4/5/18 - Medicare MDS documented a BIMS of 14, supervision with one person physical assist with toileting, continent of bladder and no toileting plan. 4/6/18 - Urinary Incontinence Evaluation documented "resolved after treatment". There was no description of what the treatment was. 4/19/18 - Quarterly MDS documented a BIMS of 14, extensive assistance with toileting with one person physical assist (decline), occasionally incontinent of bladder (decline) and no toileting plan. 4/22/18 - 4/28/18 - Admitted to hospital.	F 690	until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 690	Continued From page 50 April 2018 - Review of CNA documentation in the EMR revealed that R95 was incontinent of bladder 11 out of 73 opportunities or 15% of the time. 5/1/18 - Urinary Incontinence Evaluation provided no conclusion or plan. No evidence of a 3-Day Diary found in the record. 5/5/18 - Medicare MDS documented a BIMS of 12 (decline), extensive assistance with toileting with one person physical assist, frequently incontinent of bladder (decline) and no toileting plan. 5/6/18 - Urinary Incontinence Nursing Interventions indicated the use of individually selected absorbent products. 5/7/18 - Care plan for Resident is incontinent of urine and is unable to cognitively or physically participate in a retraining program due to his cognitive loss. Goal: Resident will have incontinence care needs met by staff to maintain dignity and comfort and to prevent incontinence related complications. Interventions included: -complete incontinence assessment at intervals according to policy and procedure, encourage to consume fluids, use appropriate continent product, offer/assist with urinal/commode as requested/needed. On 5/7/18 when the facility identified R95's cognitive decline the facility failed to implement individualized interventions for continence/toileting. 5/12/18 - Medicare MDS documented at BIMS of 9 (decline), extensive assistance with toileting	F 690		

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F 690	Continued From page 51 with one person physical assist, frequently incontinent of bladder, and no toileting plan. April 2018 - Review of CNA documentation in the EMR revealed that R95 was incontinent of bladder 25 out of 50 opportunities or 50% of the time. 5/16/18 11:25 AM - Interview with E8 (CNA) revealed that R95 uses a urinal for urine and can be assisted to toilet for bowel movements but has been totally incontinent at times. E8 stated that "he has those days he just does not know and will be incontinent". E10 (CNA) entered the conversation and confirmed the residents continence status. Both CNAs confirmed he was not on a toileting plan. 5/17/18 9:57 AM - Interview with E9 (CNA) revealed that if a resident was on a toileting plan it would be in the EMR task. E9 added that in the last year she has not had a resident on a toileting plan. 5/17/18 10:50 AM - Interview with E4 (RN, UM) revealed the resident was using a urinal and now has days when he will not let staff care for him. E4 stated that the 3-Day Diary is done on admission and how to toilet a resident is on the Task section of the EMR. 5/17/18 11:09 AM -Interview with E7 (RNAC) revealed when a decline is noticed with the MDS assessment an e mail is sent to the unit manager to do an assessment and care plan. 5/22/18 10:19 AM - Interview with E6 (RNAC) revealed that a new urinary assessment is scheduled when there is a change in coding for	F 690		

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F 690	Continued From page 52 bladder continence. It was further revealed that toileting information should be in the care plan and the CNA task including prompted or timed voiding. E6 added that as a rule the facility does not do individualized toileting programs. The facility failed to: - Comprehensively assess the resident's continence after a noted decline on 4/5/18. - Comprehensively assess the resident's continence after a further decline was noted on 4/19/18. - Comprehensively assess the resident's continence after a hospitalization and readmission on 4/2818. - Comprehensively assess the resident's continence after a further decline was noted on 5/5/18. - Implement individualized interventions for continence. 5/22/18 around 4:30 PM - Interview with E2 (DON) while reviewing above information confirmed that there were some issues with completing the incontinence assessment / 3-Day Diary. Findings were reviewed with E1(NHA), E2 (DON) and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM.	F 690		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		7/9/18

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F 692	Continued From page 53 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, interview, review of other facility documentation and review of hospital records it was determined that the facility failed to monitor the oral intake to prevent dehydration for three (R255, R72 and R74) out of 37 sampled residents. For R72 and R74 the facility failed to monitor I & O and order fluid guidelines when each resident experienced diarrhea from Clostridium Difficile (C.diff) infection. For R255, the facility failed to: - monitor intake and output and laboratory tests when the resident was experiencing diarrhea from C.diff infection. - monitor the resident's weight in the presence of C.diff diarrhea. - report continued diarrhea to the NP after treatment ended and the NP was documenting resolution. - recognize and notify the NP when R255's blood pressure dropped to an extremely low level.	F 692	A. R255 discharged from facility on 2/17/18. R72 discharged from facility on 6/1/18. R74 not identified on resident sample list provided to the facility. B. Current residents with diarrhea and/or vomiting have the potential to be affected. C. RCA of R255 completed. R72 chart reviewed. Findings indicated guidelines were needed for intake and output and additional fluids. Process placed for dietitian to recommend fluid needs during periods of diarrhea and/or vomiting. Nursing to place tasks and orders for intake and output on residents with diarrhea and/or vomiting. When a resident has diarrhea and/or vomiting, the nurse will complete the Diet Communication Form indicating on the line marked other the reason for referral.	

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F 692	Continued From page 54 The failure of the facility caused harm to R255 as the resident became unresponsive and was hospitalized for dehydration and kidney injury from not having enough fluid in the body requiring emergent treatment including intravenous fluids and tube feeding. Findings include: Cross Refer F684, Example 3 and F711. 1. Review of R255's clinical record revealed: 1/3/18 - Readmission to facility for rehabilitation after hospitalization and receiving antibiotics for pneumonia. Care Plan - 1/3/18: Nutritional Risk: Goal to maintain a stabilized weight of 150 pound (plus or minus 4%). Interventions included: Encourage 100% consumption of all fluids provided; Provide regular liberal diet; Offer snacks. - 1/5/18: Exhibits or is at risk for complications of infection related to history of pneumonia and (as of 1/30/18) C.diff. Interventions included: Monitor for changes in nutritional status such as change in intake, ability to feed self, unplanned weight loss or gain, abnormal labs and notify dietician / physician as indicated; Monitor vital signs and report to physician as indicated. 1/10/18 - Admission MDS Assessment recorded that R255 had dementia with moderate cognitive impairment but was one point away from severe cognitive impairment. - 1/17/18: Care plan for Risk for Dehydration as evidenced by infection, and/or nausea, diarrhea, vomiting with the goal of not exhibiting signs/symptoms of dehydration as evidenced by moist mucous membranes, no fever, vital signs	F 692	The Form will be placed in the dietitian mailbox for follow up. Licensed nurses will be educated on this new process (Attachment A). D. Center Nurse Executive/designee will complete audits of the resident population to identify those with diarrhea and/or vomiting and verify that I & O and fluid needs were in place (Attachment BB). Audits will occur daily until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 692	Continued From page 55	F 692		

and labs at baseline. Interventions included: Monitor for signs/symptoms of dehydration (increased temperature, decreased [urine] output, mental status changes, dry mucous membranes, orthostatic hypotension, and increased heart rate); Monitor lab work as ordered and report as indicated; Contact precautions (added 1/23/18) while symptomatic.

1/21/18 - Weight 146.4 pounds.

1/21/18 (10:29 PM) - Nursing note documented R255 was having loose watery stools. "This is a continuous thing with the resident."

1/22/18 - NP note documented resident stool was positive for C.diff and ordered an antibiotic for 10 days for the infection.

1/23/18 - Nutrition note documented R255's weight had been relatively stable during this admission. Resident consuming 75-100% of regular diet meals. Currently positive for C.diff, will monitor for weight changes.

January, 2018 - February, 2018
a. Bowel Movements per CNA Flowsheets:
- loose stools: January 9-11, 13, 15, 30; February 1, 6, 7, 13. (10 days)
- watery stools: January 12, 14, 16-17, 20-29, 31; February 2-5, 8-12, 14-17. (28 days)

b. Intake per CNA Flowsheets and eMARs:
- meal intake average - January 81% (7 meals not recorded); February 54.3%. This was a 26.7% decrease of meal intake.
- shifts when a drink "other than with meals" was signed by the CNA as being accepted by R255: January 20 days, 13 evenings, 7 nights.

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F 692	Continued From page 56 February 12 days, 9 evenings, 4 nights. - nurses signed off every shift that R255 was encouraged to drink fluids. The amount of liquids consumed were not recorded so it was unclear how much R255 drank during or between meals. Abnormal Laboratory Results (normal range in parenthesis): - 1/8/18: Sodium 146 (136-145), Chloride 112 (98-107), Potassium 3.2 (3.5-5.1), Hemoglobin 8.0 (13.6-17.5); Hematocrit 24.4 (41-52). - 1/15/18: Chloride 110 (98-107), Potassium 3.3 (3.5-5.1). - Potassium level tested: January 11, 29, 30, 31; February 1, 2, 5, 6, 7, 8, 9, 12, 16.[Potassium levels ranged from 2.4 to 4.0 and the resident had been receiving potassium orally.] Review of physicians' orders found no other laboratory blood tests were performed to monitor the resident's hydration status. 2/6/18 - Nutrition note documented the trigger for weight loss was from an old admission weight. Weight loss likely in association with disease state. Recent diagnosis of C.diff and continues with loose stools. Will monitor. Slight weight increase in past 1 week. Current 148.3 pounds (from 2/5/18). There were no further weights obtained. 2/6/18 - NP Progress Note documented R255 completed the course of antibiotics for C.diff, which had resolved. Monitor for reoccurrence. [C.diff was noted as resolved in the NP Progress Note despite continued loose and watery stools.]	F 692		

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F 692	Continued From page 57 2/7/18 - 2/9/18 - NP Progress Notes recorded the C.diff infection had resolved. [C.diff was noted as resolved in the NP Progress Note despite continued loose and watery stools.] There was no evidence in the nursing progress notes that the NP was informed of R255's continuing diarrhea. 2/8/18 - Nursing note recorded R255 fed self meals, appetite good. CNA flowsheet recorded R255 ate 100% breakfast and lunch. 2/14/18 - Facility Grievance / Concern Form documented family concerns including, but not limited to, "not getting enough to drink" in the water mug and losing weight and may need more staff assistance with meals due to getting tired. Facility response involved that water pitchers were to be checked and refilled at the beginning and end of the shift. Resident weight 2/5/18 was 148.3 and R255 had been observed effectively feeding self. Staff consistently set-up the meal tray and supervised with meals. Care conference scheduled for 2/15/18 was rescheduled to 2/20/18 since son unable to attend. [Despite family concern, no weights or I&O were ordered to effectively monitor this resident.] 2/15/18 (4:21 PM) CNA flowsheet - Blood pressure 93/48 which was extremely low for R255, who usually ran 120-150 systolic [top number of the blood pressure]. There was no nursing progress note acknowledging the low blood pressure, that the blood pressure was repeated to verify accuracy, that the NP was made aware or that the blood pressure was obtained on the subsequent night and day shifts.	F 692		

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F 692	Continued From page 58 2/16/18 - NP Progress Note recorded that R255 was less alert than usual. Resident informed the NP that s/he was having diarrhea and did not feel well. An antibiotic was ordered for recurrent infection. 2/16/18 (6:57 PM) - CNA flowsheet showed R255's blood pressure even lower at 79/44 without a nursing progress note acknowledging the blood pressure, that the blood pressure was repeated to verify accuracy or that the NP was notified. 2/17/18 (12:06 PM) - Nutrition Note documented family spoke with dietician about decline in intake over past few days since R255 refused 3 meals and only ate 25% when consuming meals. Discussed diarrhea and possible nutrition supports such as BRAT (banana, rice, applesauce and toast) diet and consider snacks of yogurt, ice cream and house shake, if tolerates without increase in diarrhea. Wasted appearance with STAT labs ordered. Nursing reports that fluids encouraged and may possibly need IV [intravenous] fluids depending on labs. RD to follow for acceptance of supplements and meal intakes. Noted in orders that resident is to be fed all meals and snacks until his condition improves. 2/17/18 (12:50 PM) - Nursing Progress Note documented R255 with increased weakness and poor appetite. Spoke with physician and STAT labs ordered. Family at bedside encouraging fluids frequently. Sodium level returned at 160 (136-145). 2/17/18 (1:50 PM) - Nursing Progress Note documented resident had unplanned transfer [sent out 911 to emergency department].	F 692		

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F 692	Continued From page 59 2/17/18 - Ambulance care report documented the ambulance arrived at the facility at 1:38 PM and found R255 was unresponsive at 1:42 PM but was alert and following commands by 1:47 PM. Resident with "altered mental status and, per [facility] staff, high potassium." Family reported R255 was acting appropriate the evening prior (2/16/18) but was talking at lunch time but was weak and "not himself." Review of R255's Hospital Records revealed: - 2/17/18: Admitted to hospital with admission diagnoses including acute metabolic encephalopathy [altered mental status] due to severe hypernatremia (high sodium level from dehydration). Hypernatremia due to poor oral intake and C.diff diarrhea. Abnormal electrolyte blood tests: Sodium 161 (136-145), Chloride 136 (98-107), Potassium 5.2 (3.5 - 5.1). Impaired kidney function blood tests: BUN 30 (7-18), Creat 1.70 (0.67-1.17). - 2/18/18: Weight 53.1 kg (measured) = 116.8 pounds. - 2/18/18 Nutritional Assessment: included nutrition diagnosis of malnutrition probably related to diarrhea. Start tube feeding and increase to goal rate of 55 mL per hour. - 2/20/18: Renal (kidney) Consult documented acute kidney injury probably related to hypovolemia [low amount of fluid in body]. During an interview with E23 (NP) on 5/21/18 around 10:00 AM when asked what kind of lab tests are ordered when residents have diarrhea or vomiting, E23 said "all kinds" including potassium, renal [BUN, creatinine], sodium, complete metabolic panel, and sometimes CBC but it depended on the resident.	F 692		

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F 692	Continued From page 60 During an interview with E2 (DON) on 5/21/18 around 11:50 AM to clarify whether I&O was to be a nursing or physicians order, it was determined that it could be either, but the fluid guidelines must be ordered. During an interview with E18 (Corporate Nurse) on 5/22/18 around 10:50 AM E18 confirmed weekly weights were not completed following admission and there was no acknowledgement or notification for the low blood pressures. R255 experienced harm due to the facility's failed to: - monitor intake and output and laboratory tests when the resident was experiencing diarrhea from Clostridium Difficile (C.diff) infection. - monitor the resident's weight in the presence of C.diff diarrhea. - report continued diarrhea to the NP after treatment ended and the NP was documenting resolution. - acknowledge, repeat, monitor or notify the NP when the blood pressure was extremely low. During the survey it was identified that there were two other residents experiencing diarrhea and/or vomiting that did not have fluid guidelines or I &O performed. 2. Review of R72's clinical record revealed: R72 had watery and loose stools prior to 4/28/18 hospitalization. 5/10/18 - R72 returned to facility after treatment for pneumonia and dehydration with C.diff	F 692		

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F 692	Continued From page 61 infection with persistent diarrhea. May, 2018 - Review of physicians' orders, eMAR and eTAR found guidelines for additional fluids were not ordered and intake and output monitoring was not performed in the presence of loose and watery stools. 3. Review of R74's clinical record revealed: 4/14/18 - R74 was sent to the hospital for vomiting. 5/5/18 - Diarrhea stool presumptive positive for C.diff infection. May, 2018 - Review of eMAR and eTAR found R74 continued with watery and loose stools and fluid guidelines for additional fluids were not ordered. Intake was recorded by nurses since the resident received nutrition by tube feeding. Findings were reviewed with E1 (NHA), E2 and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		7/9/18

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F 695	Continued From page 62 by: Based on observation and interview it was determined that for two (R22 and R39) out of 2 sampled residents reviewed for oxygen the facility failed to ensure the oxygen humidifier and tubing were changed weekly. Also, R22's replacement tracheostomy supplies were not easily accessible and in a visible location in the event of an emergency since the facility stored some supplies in the resident's dresser that was used for personal clothing. Findings include: 1/1/04 - Facility policy entitled Oxygen: Nasal Cannula (revised 12/8/14) included that the humidifier should be labeled with the date. The entire set-up [all tubing] is to be replaced every 7 days. 1. Facility policy entitled Tracheostomy Emergency Bedside Supplies (last reviewed 3/1/16) included that each tracheostomy patient will have the following supplies available at bedside: - Spare tracheostomy tube with obturator of the same make and size currently used, or one size smaller if the same size is not available; - Syringe; - Barbed connector for oxygen connection; and - Oxygen capable of reaching 15 liters per minute. The following was reviewed in R22's clinical record: 2/22/18 - Physicians' orders included: - Oxygen concentrator set at 4L/min [liters per minute]. - Tracheostomy (trach) suctioning as needed. - Pulse ox every shift to keep oxygen level greater	F 695	A. R22 had trach and emergency supplies relocated to a more easily accessible area on and all oxygen supplies replaced and dated on 5/25/18. R39 had orders for oxygen use placed and all oxygen tubing dated on 5/17/18. B. Current residents with oxygen and/or respiratory supplies have the potential to be affected. C. Residents with oxygen in use had an audit of physician orders and date on supplies completed on 5/18/18. Nursing staff will be educated regarding emergency equipment availability and requirement for physician orders and tubing changes (Attachment A). D. Center Nurse Executive/designee will complete audits of 10% of the resident population to determine if oxygen orders are complete and oxygen tubing is changed and dated (Attachment CC) and emergency respiratory supplies are easily accessible (Attachment DD). Audits will occur daily until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until 100% compliance is achieved on 5 consecutive evaluations.Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 695	Continued From page 63 than or equal to 92. - Change trach ties after bath/shower and as needed. - Change disposable inner cannula every shift and as needed. - #6 Shiley and ambu bag at bedside, check every shift. - Tracheostomy care every shift and as needed. 2/22/18 Care Plan problem for Resident exhibits or is at risk for respiratory complications related to tracheostomy. Approaches included: - keep ambu bag and extra trach tube and obturator in resident room, keep head of bed at 30 degrees, monitor and report oxygen saturations levels, trach care per MD orders, suction as needed. 5/16/18 (10:15 AM) - R22 was observed to be alert, oriented and ambulatory. A room observation for tracheostomy supplies revealed the following: - Oxygen humidifier bottle hooked directly to the oxygen concentrator was empty and dated 5/2/18. The disposable humidifier bottle should be changed weekly per facility oxygen policy but the current humidifier was 14 days old. - A nebulizer reservoir for breathing treatments was on the bedside table and not in a protective plastic bag to protect it from contamination when not in use. - An Ambu bag (emergency equipment to pump air into patient's lungs) was placed behind the television on dresser next to R22's bed, out of direct view. - The oxygen machine was turned around so the amount of oxygen the resident was being administered was not readily visible. - A large box of miscellaneous supplies was in	F 695		

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F 695	Continued From page 64 front of the oxygen machine making it difficult to access. - Emergency oxygen tank was positioned at top left side of bed (on opposite side of bed from all other respiratory equipment). - Tracheostomy collar, oxygen tubing, humidification bag, suction equipment, and nebulizer equipment were not dated. The oxygen policy reflected that all oxygen-related items should be changed weekly. During an interview with E15 (LPN) on 5/16/18 at 10:45 E15 revealed that the humidifier bottle dated 5/2/18 was probably not necessary because an Airvo machine was humidifying the oxygen. E15 was not sure of where the tracheostomy emergency equipment was located in the resident's room but did locate an Ambu bag after a few minutes. E15 looked through the tracheostomy supplies and could not locate an outer cannula (permanent tube) to replace the tracheostomy if it accidentally came out. E15 misidentified an inner cannula as an outer cannula and the surveyor clarified that the inner cannula E15 found was not an emergency outer cannula with cuff and obturator. E15 said they (outer cannulas) were probably in the supply room and would ask. 5/23/18 around 12:30 PM - Follow-up interview with E15 and observation in R22's room revealed that the above supplies were still not dated. E15 was asked again about the back-up tracheostomy supplies and could not find the outer cannula (Shiley #6). After a few minutes, all the needed emergency supplies were found in the top and bottom dresser drawers near the bed. 5/23/18 around 12:30 PM - Interview with E3	F 695		

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F 695	Continued From page 65 (ADON, RN, UM) and E2 (DON) regarding emergency supplies reported that emergency trach supplies were kept in residents personal drawers. Adding that this was not their policy, but was their practice, at the facility indicating that was where they always kept resident supplies. E2 and E4 were made aware that E15 had difficulty locating the supplies. 2. Review of R39's clinical record revealed: 7/26/17 - Physician's orders included continuous oxygen after hospitalization for respiratory failure. August, 2017 - May 2018 - Review of eMARs found no evidence that the nasal cannula and disposable humidifier bottle were changed weekly. 5/15/18 (11:00 AM) - Observation of undated humidification bottle and nasal cannula. 5/17/18 (11:30 AM) - Humidification bottle and nasal cannula not dated. During an interview with E2 (DON) on 5/17/18 at 12:49 PM to determine where weekly respiratory equipment changes would be found, E2 said if not recorded on the eMAR then it would not be anywhere else. E2 informed the surveyor on 5/1/7/18 at 1:05 PM that the order was added to the computer so the weekly change of the respiratory equipment would appear on the eMAR. Findings were reviewed with E1(NHA) and E2 at the exit conference on 5/23/18 at 11:45 AM.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697		7/9/18

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F 697	Continued From page 66 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R72) out of 2 residents sampled for pain management the facility failed to ensure a complete pain assessment was conducted to evaluate the effectiveness of pain medication. Findings include: The pain management standards were approved by the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. The facility's Pain Management policy dated 3/1/18 did not address the use of pain scales and the need for consistent assessment using the same pain scale before and after administration of PRN pain medication. The following was reviewed in R72's clinical record: 2/26/18 - APAP 325 mg take two tablets every six hours as needed for pain.	F 697	A. R72 was discharged on 6/1/18. B. Current residents with Tylenol/APAP orders have the potential to be affected. Current residents receiving as needed analgesics have the potential to be affected. C. All charts reviewed for duplicate orders on 6/19/18. Nursing staff will be educated for use of pain scale post medication administration (Attachment A). D. Center Nurse Executive/designee will complete chart audits for duplicated Tylenol/APAP orders (Attachment EE) and use of pain scale post medication administration (Attachment FF). Audits will be occur daily until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendation.	

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F 697	Continued From page 67 2/26/18 - Tylenol 325 mg take two tablets every six hours as needed for pain or temperature. Both the above orders are for the same medication and were listed separately on the MAR. The duplicate entry could potentially lead to the resident receiving too much of the medication which has a maximum daily limit due to its effect on the liver. 3/11/18 (revised 5/18/18) - Care plan for Resident exhibits or is at risk for alterations in comfort related to general discomfort interventions included: -utilize pain scale March 2018 MAR - 7 doses of as need APAP/Tylenol were administered with no pain scale used post administration only E for effective. April 2018 MAR - 3 doses of as need APAP/Tylenol were administered with no pain scale used post administration only E for effective. May 2018 MAR - 1 dose dose of as need APAP/Tylenol was administered with no pain scale used post administration only E for effective. 5/22/18 12:14 PM - Interview with E2 (DON) revealed if staff just entered E for effective on the MAR there was no post pain scale conducted. Findings were reviewed with E1(NHA), E2 and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM.	F 697		

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F 711	Continued From page 68	F 711		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review, interview, review of other facility documentation and review of hospital records it was determined that the facility failed to ensure the medical provider reviewed the total program of care for one (R255) out of 4 sampled residents for nutrition / hydration. Findings include: Cross Refer F692 example 1 Review of R255's clinical record revealed: 1/5/18 - Care plan problem for Exhibits or is at risk for complications of infection related to history of pneumonia and as of 1/23/18 C. diff. [Complications of C. diff infection can include dehydration with loss of electrolytes and kidney damage]	F 711	A. R255 was discharged from the facility 2/17/18. B. Current residents with hypotension and diarrhea have the potential to be affected. C. Review of all residents for hypotension and diarrhea in the last 14 days completed on 6/20/18. Practitioner notification completed for identified residents on 6/20/18. Nursing staff will be educated regarding practitioner notification (Attachment A). D. Center Nurse Executive/designee will complete audits of 10% of the resident population for hypotension (Attachment GG) and diarrhea (Attachment HH).	7/9/18

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F 711	Continued From page 69 A. BM Monitoring February, 2018 - CNA flowsheet documented R255 had loose and/or watery stools: - 2/5/18: 3 shifts, 1 were watery. - 2/8/18: 3 shifts, 1 were watery. - 2/9/18: 1 shift, 2 were watery. - 2/10/18: 2 shifts, 1 were watery. - 2/11/18: 3 shifts, 3 were watery. - 2/12/18: 3 shifts, 3 were watery. - 2/13/18: 2 shifts, no watery. - 2/14/18: 3 shifts, 2 were watery. - 2/15/18: 3 shifts, 2 were watery. February 6, 8 and 9, 2018 - NP Progress Notes included that C. diff infection "resolved" in spite of continuing loose or watery stools. 2/16/18 - NP Progress Note documented recurrence of diarrhea. During an interview with E23 (NP) on 5/22/18 at 12:00 PM E23 stated s/he gets the bowel movement information from nurse and patient. "I guess if the aide does not tell the cart [sic] nurse, the nurse would not know about the diarrhea." The resident "kept telling me it was improving." B. Electrolyte Monitoring Abnormal Lab Test Results (normal range in parenthesis): - 1/8/18: Electrolytes: Sodium 146 (136-145), Potassium 3.2 (3.5-5.1), Chloride 112 (98-107), Calcium 7.9 (8.5-10.1). Blood count with anemia: Hemoglobin 8.0 (13.6-17.5), Hematocrit 24.4 (41-52). Kidney tests were within normal range. - 1/15/18: Potassium 3.3, Chloride 110, Calcium 8.2, Hemoglobin 9.0, Hematocrit 28.2. 1/22/18 - Resident diagnosed with C. diff infection	F 711	Audits will occur daily until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 711	Continued From page 70 with persistent diarrhea. January, 2018 - February, 2018 - Physicians' orders for laboratory testing included only potassium: January 22, 29, 30 and 31; February 1, 2, 5, 6, 7, 8, 9, 12 and 16. During an interview with E23 (NP) on 5/21/18 around 10:00 AM when asked what lab testing would be done if a resident had diarrhea or vomiting, E23 stated "all kinds" including potassium, renal [BUN, creatinine], sodium, complete metabolic panel, and sometimes CBC but it depended on the resident. The facility failed to ensure the resident's total program of care was reviewed including to order and monitor laboratory tests to monitor hydration and electrolyte status during the period of time R255 exhibited diarrhea. C. Blood Pressure January, 2018 - February, 2018 - Vital signs on the CNA flowsheet recorded the resident's systolic blood pressure was usually taken 2-3 times a day the reading ranged from 120-150 with an occasional reading in the 110s or 160s. - eMAR reflected two blood pressure pills, each ordered once a day, scheduled at 8:00 AM. - NP Progress Notes showed that the latest vital signs and weight flows into the electronic note along with the date and time the data was obtained/entered into the computer. - There were several blood pressures that were extremely low for R255: January 30 (1:35 PM) 99/41 and (3:07 PM) 95/52;	F 711		

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F 711	Continued From page 71 January 31 (8:51 PM) 104/49; February 3 (4:44 PM) 105/52; February 15 (4:21 PM) 93/48; February 16 (6:57 PM) 79/44. - NP Progress Notes note found R255 was seen: January 30 (12:59 PM) BP from 3:18 AM was 164/78. January 31 (6:16 PM) BP from 8:14 AM was 159/69. February 1 (1:04 PM) BP from 6:57 AM was 151/54. February 16 (12:59 PM) BP from February 15 at 4:21 PM was 93/48 (the last BP taken). There was no evidence in the notes that the NP was aware of the low blood pressures as the plan for "Hypertension. Continue [name/dose of one of the BP medications] po daily, along with other cardiac meds" was written on January 30. On the January 31, February 1 and 16 notes "Adjust as indicated. Stable" was added to the previous statement. However, no adjustments to the blood pressure medications were prescribed. During an interview with E23 (NP) on 5/22/17 around 12:00 PM E23 stated that s/he was not aware that the resident had low blood pressure readings. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/23/18 at 11:45 AM.	F 711		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 725		7/9/18

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F 725	Continued From page 72 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to have sufficient nursing staff to provide care to all residents to ensure residents received assistance with toileting, showers and meals. Findings include: Interviews performed on 5/14/18, 5/15/18 and 5/17/18 with 15 residents who desire to remain anonymous revealed the following: - 5/14/18 at 10:20 AM: A1 stated that call bells are answered up to 30 min after they are rang. - 5/14/18 at 12:17 PM: A2 said morning is the worst time to get assistance and opted to get	F 725	A. The facility has met with and followed up with residents' documented grievances. B. Current residents have the potential to be affected. C. The Scheduling Manager will staff the facility at or above minimum staffing requirements. The Facility Leadership will round daily to determine specifics about sufficient nursing staff and assess staffing needs based upon feedback from residents.	

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F 725	Continued From page 73 bathed and out of bed at 5 AM, as to not wait for the day shift and be late for morning activities. - 5/14/18 at 1:43 PM: A3 said there is "not enough staff. It takes a long time to answer the call bell. One time had I had an accident (urine) waiting to go to bathroom." A3 explained that without a designated shower CNA residents have a hard time getting their showers. Also they use aides from the floor in the dining room, making it more difficult to get help during meals. - 5/14/18 at 2:14 PM: A4 There is not enough staff here. During all shifts something happens all the time. No specific examples try to get it done. - 5/14/18 at 2:40 PM: A5 said that there is "not enough staff, especially on 3-11 shift. I waited 1 hour 45 minutes at 6 PM" one evening. - 5/14/18 at 2:52 PM: A6 said that there was "not enough staff" and they "don't answer call bell right away. I have to wait half an hour." - 5/14/18 at 4:30 PM: A7 said there is not enough staff and "they are not organized." Therapy staff help when there is not enough CNAs. - 5/15/18 at 8:33 AM: A8 said waits are long when there are "people calling out" and "a lot pulled to the other unit." - 5/15/18 at 9:08 AM: A9 said the facility needs more help at night, especially to answer call bells and help give showers. - 5/15/18 at 9:43 AM: A10 said the staff "take a long time almost every time I need help." And the resident has had an accident (urine) while waiting for assistance. - 5/15/18 at 9:53 AM: A11 said staff "always take a long time" to answer the call bell. - 5/15/18 at 11:14 AM: A12 stated after ringing the call bell, the wait has been as long as 30 min, especially around meal times. - 5/17/18 between 10:05 AM and 11:35 AM: A13 explained that when ringing a call bell, nursing will	F 725	D. The Center Nurse Executive/designee will complete audits (Attachment II) on 10% of the resident population daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 5 consecutive reviews. Results of audits will be presented to the monthly QAPI committee meetings for review and recommendations.	

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F 725	Continued From page 74	F 725		

take 45 min to 1 hour to respond. And, "we have issues [getting help or care] when our CNA goes to lunch." A13 also pointed out that residents aren't receiving the help they need to get out of bed and ready for 10 AM or 10:30 AM activities they wish to attend.
- 5/17/18 between 10:05 AM and 11:35 AM: A14 said after ringing the call bell nursing staff can be seen sitting at the station not paying attention to the bell and it is "horrible to find help during meal times."
- SS13 and SS14 said that for several months, there have been shifts where the CNA did not visit them at all. They also noted that their medications are often given late. There are less nurses than in the past, causing residents to receive medications later than ordered, on a regular basis.
- 5/17/18 between 10:05 AM and 11:35 AM: A15 expressed concern for once being left in the shower alone. A15 bathed, dressed, and left the shower room without the supervision required.

Record review of Resident Council minutes revealed the following concerns:
6/5/17 - one resident is not getting assistance cutting up food during meal in dining room. Other residents assist.
8/7/17 - no assistance for showers, due to lack of a designated CNA for this role, lack of help when being seated for meals.
10/2/17 - residents are not getting assitance to be ready for morning activities, residents are not getting help, in the dining room, when it's time to be seated for a meal.
11/6/17 - residents are still not getting asssistance to be ready for morning activities, staff are still not available (or are in the room, but do not help) to help seat residents for meals in

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F 725	Continued From page 75 the dining room 12/4/17 - residents are not getting showers due to no designated CNA, residents are seating themselves at dining times, and staff is available and present, but note being of assistance. 1/2/18 - unit 1 residents still have trouble getting CNAs to give them showers, residents are helping other residents in the dining room because no staff is present. 2/13/18 - call bells are not being answered in a timely manner. 3/5/18 - assistance is not present, or is present but does not assist, during dining in dining room. 4/2/18 - there is "not enough staff" and call bells on 3-11 and 11-7 are not being answered in a timely manner. 5/7/18 - residents still feel they are not getting the care they need, call bells are not being answered in a timely manner, staff at the nurse's station are turning the call bells off. Call bell audits from the month of March 2018 were reviewed. Included on the audit form are columns for date, room number, resident, whether the bell was answered or not, and the ring time in minutes. During an interview on 5/22/18 at 2:29 PM, when asked about more current audits, E12 (RN) said the facility had stopped performing the audits (the last dated audit log provided was from 4/2/18). The logs were collected by E12, then results are given to quality assurance committee. E12 said that audits had started back up this week, but no logs had been turned in yet. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM	F 725		

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		7/9/18

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F 758	Continued From page 77 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the recommendation from the Psychotropic Medication Use Evaluation was acted upon for one (R76) out of 5 sampled residents for unnecessary medication review. Findings include: Review of R76's clinical record revealed: Care plan problems (last reviewed 2/8/18) - 4/26/16: Risk for complications due to use of psychotropic medications. Interventions included: complete behavior monitoring flowsheet; gradual dose reduction (GDR) as ordered; monitor for continued need of medication as related to behavior. - 1/24/17: Disruptive/demanding behavior as evidenced by telling staff they cannot leave to care for others, interrupting when staff with roommate (last reviewed 2/8/18) with goal of less than 10 episodes in 100 days. - 1/30/17: Socially inappropriate behavior as evidenced by false accusations, telling lies about staff with the goal of having less than 10 episodes in 100 days. 5/8/17 - Physicians' orders included an	F 758	A. R76 had a GDR of her psychotropic medication on 5/21/18 and a new order for evaluation by MedOptions placed on 6/5/18 B. Current residents on psychotropic medication have the potential to be affected. Facility report received from MedOptions indicating the date of last evaluation and recommendations. Pharmacy listing of all residents on psychotropic medications sent to MedOptions for review. C. All Psychotropic Medication Use Evaluations are completed by the CRC. A new process was developed for the CRC to notify Social Services for any recommendation for additional assessment needed. The Social Services staff will make the referral to MedOptions and verify that visit occurred. In addition, the Pharmacy Consultant Forms will be reviewed by the CNE/designee for follow up accordingly. The CRCs, Social Workers, and Nurse Leadership will be educated about this new process.	

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F 758	Continued From page 78 antipsychotic at bedtime (a decrease in dose from prior order) for dementia with behavioral disturbance. 8/3/17 - Psychiatric services did not recommend GDR since likely to impair resident function. 2/27/18 - Psychotropic Medication Use Evaluation recommendations included "Recommend additional clinician assessment of behavior symptoms." Review of the record found no evidence that the assessment of behavior symptoms was conducted after the February 2018 recommendation. R76 was last seen by name of psychiatric service 1/2/18. February, 2018 - May, 2018 - Behavior Monitoring flowsheets documented minimal behaviors ranging from 5 episodes in Feb, 2 in March, 0 in April, and 1 in May and no evidence of considering a GDR. During an interview with E2 (DON) on 5/21/18 at 11:37 AM to review the resident's antipsychotic, E2 said that a GDR was conducted May 2017 when the dose went from 300 mg to 200 mg. E2 clarified that the recommendation about additional clinician assessment of behaviors meant that the psychiatric service should see the resident. During an interview with E2 on 5/21/18 at 2:26 PM E2 confirmed that the last time the psychiatric service saw R76 was 1/2/18. E2 provided a copy of the 5/9/18 signed doctor's agreement to the pharmacy suggestion for psychiatry to follow. E2 added "I will put it in the computer."	F 758	D. Center Nurse Executive/designee will complete audits of Psychotropic Medication Use Evaluations and Pharmacy Consultant Forms to determine if additional clinician evaluation was recommended. The audit tool will be implemented for any recommended MedOptions evaluations and GDR recommendations (Attachment JJ). Audits will occur monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendation.	

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F 758	Continued From page 79 The arrangement for the psychiatric service to see R76 was not completed until 5/21/18 even though it was recommended 2/27/18. This finding was reviewed with E1 (NHA), E2, and E3 (ADON) on 5/23/18 at 11:45 AM.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the	F 761	A. E26 is not longer at the facility.	7/9/18

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F 761	Continued From page 80 facility failed to ensure that multiple stock bottles of medications were stored in locked compartments unless under direct supervision of the nurse. Findings include: Observation of the medication cart on the hallway outside room 206 on 5/22/18 revealed: - 10:06 AM: Five bottles of stock meds sitting on top of med cart and the nurse was no where to be found. Each bottle contained oral medications: low dose aspirin, stomach acid reducer, allergy medication, iron, laxative. - 10:08 AM: E26 (LPN) returned to the medication cart from room 206, then went into the next room to see if that resident was ready for their morning medications. - 10:10 AM: E26 returned to the medication cart and prepared medications for the next resident. - 10:15 AM: E26 left the medication cart to administer the medication in the resident's room, leaving an additional stock bottle (Tylenol) on top of the cart, along with the other 5 bottles...now 6 bottles of stock medications were unattended on the cart. This finding was reviewed with E1 (NHA), E2 (DON), and E3 (ADON) on 5/23/18 at 11:45 AM	F 761	B. Current residents have the potential to be affected. C. Nursing staff will be educated about storage of medications (Attachment A). D. The Center Nurse Executive/designee will complete audits of medication storage (Attachment KK). Audits will occur daily until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		7/9/18

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F 812	Continued From page 81 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to serve food in accordance with professional standards for food service safety. Findings include: An observation was made during lunch service on 5/14/18 of E29 (Dietary Aide) pulling the food cart, with gloved hands into the hallway on 5/14/18 at 12:09 PM. E29 then plated a sandwich using the same gloved hands to touch the sandwich at 12:11 PM. E29 pulled the cart again, still wearing the same gloves and plated another sandwich at 12:15 PM by touching a sandwich with gloves that were used to move the cart. According to the State of Delaware Food Code, effective 5/11/14, gloves shall be used for only one task, and discarded when interruptions occur in the operation. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 5/23/18 at 11:45 AM	F 812	A. The FSD met with the dietary aide on 5/15/18 to discuss the policies for Food Handling and Hand Washing. B. Residents being served lunch from the food cart have the potential to be affected. C. The Dietary staff will be educated regarding Hand Washing and Food Handling. (Attachment LL). D. The FSD/designee will complete daily audits (Attachment MM)of Food Handling and Hand Washing until 100% compliance is achieved on 3 consecutive evaluations. Then weekly until 100% compliance is achieved on 3 consecutive evaluations, then monthly until 100% compliance is achieved on 3 consecutive evaluations. Results of audits will be presented to the Quality Assurance Improvement Committee for review and recommendations.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		7/9/18

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F 867	Continued From page 82 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that the facility failed to monitor quality assessment and assurance activities to ascertain compliance. Findings include: During an interview with E1 (NHA) on 5/23/18 at 8:29 AM to review the quality assessment and assurance program, E1 described numerous areas addressed at the monthly meetings, including but not limited to, breakfast temperatures, turning and repositioning, HIPAA, call light auditing and lost laundry. When asked how long the facility audits after implementation of changes, E1 indicated that no audits were completed for the HIPAA initiative. During an interview with E2 (DON) on 5/23/18 at 8:41 AM to review the pressure ulcer initiative, E2 stated that the wound nurse position was vacant and that E3 (ADON) will take over as skin coordinator and also monitor prevention. When asked about the completion of audits to monitor the effectiveness of interventions, E2 confirmed that leadership had not been doing audits. When asked about audits for monitoring I&O and fluid guidelines for residents with diarrhea or vomiting, E2 confirmed no audits were completed. This finding was reviewed with E1 and E2 at the	F 867	A. Cross refer to F558, F565, F584, F623, F640, F655, F657, F684, F686, F689, F690, F692, F695, F697, F711, F725, F758, F761, F812, F880 for resolution on residents affected. B. Cross refer to F558, F565, F584, F623, F640, F655, F657, F684, F686, F689, F690, F692, F695, F697, F711, F725, F758, F761, F812, F880 for resolution on other residents affected. C. The QAPI Committee completed a RCA on June 20, 2018 to identify underlying causes for audits not being completed for identified areas of concern in the monthly QAPI meetings. As a result of the RCA, a new form was developed to use at QAPI meetings to track audits for areas of concern identified (Attachment NN). The QAPI Committee members will be educated regarding the policy for QAPI in the center and the importance of monitoring quality assessment and assurance activities to ascertain compliance, which includes use of audit tools. The education included discussion about the goals of the Committee not just reporting the data, but	

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F 867	Continued From page 83 exit conference on 5/23/18 at 11:45 AM.	F 867	being proactive and recommending preventative measures to ensure quality outcomes and sustain improvement (Attachment OO). The Committee will identify and prioritize areas of needed improvement, assign improvement teams, audit and track progress, and make recommendations as needed for sustained improvement. D. The QAPI Committee will meet weekly for 4 weeks to discuss the survey plan of correction action plans, review audits, and determine if revisions are needed to the action plans. The QAPI Committee will then meet monthly to review and monitor ongoing quality improvement activities, which includes discussion of audit results, as well as continued changes in action plans to achieve sustainable improvement. The QAPI/QAA Improvement Activities Audit Tool (Attachment NN) will be utilized for the next 6 months for compliance with monitoring quality assessment and assurance. Results of all audit tools will be presented to the QAPI Committee for review and recommendations.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		7/9/18

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F 880	Continued From page 84 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 85 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to follow acceptable isolation precautions for one (R72) out of 2 residents on isolation precautions. Findings include: The following was reviewed in R72's clinical record: 5/10/18 - New diagnosis C.diff infection and orders for an antibiotic. There was no physicians' order for a specific type of isolation or precautions. Residents with C.diff should be on contact precautions with the use of soap and water for hand hygiene. 5/14/18 - R72's room noted to have a plastic 4 drawer cart outside room containing personal protective equipment (disposable gowns, gloves	F 880	A. R72 was discharged from the facility on 6/1/18. B. Current residents have the potential to be affected. C. The nursing staff will be educated regarding isolation procedures i.e. gown and glove when entering room, stop sign at doorway, and use disposable equipment (Attachment A). D. The Center Nurse Executive/designee will perform audits on all residents on isolation precautions to determine that contact precautions are maintained (Attachment PP). Audits will occur daily until 100% compliance is achieved on 3 consecutive evaluations, then weekly until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	C 05/23/2018

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SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

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F 880	Continued From page 86 and masks), a blood pressure cuff and a stethoscope. There was no sign indicating that staff / visitors should check with nurse before entering. 5/15/18 - A plastic sign to check with nurse before entering room was hung on the resident's door. 5/16/18 3:53 PM - E17 (CNA) was observed pushing a wheeled blood pressure monitoring device into R72's room without donning any protective equipment. Precautions for resident care would have been a minimally a disposable gown and gloves. E17 proceeded to take R72's vital signs at the bedside. As E17 exited the room s/he crossed the hall and used alcohol cleanser to clean hands (hand hygiene should be with soap and water since alcohol is not effective to remove C.diff). E17 was approached by the surveyor and asked why the resident was on isolation, E17 did not know. E17 was informed and instructed that the equipment in room would need to be cleaned. E17 responded that there were no alcohol wipes in the room. At that time the aide was informed that alcohol was not an effective cleaning method and she would have to have speak to nurse about proper cleaning measures. E17 stated she did not mean alcohol wipes she meant the "other" cleaning wipes. 5/17/18 about 11:30 AM - Surveyor spoke with E3 (ADON, RN, UM) and E18 (Corporate Educator) about the above observation. The surveyor also mentioned that there was a blood pressure cuff and stethoscope in the supply cart outside the room and that these items should be kept in the room and not stored outside the room. Both E3 and E18 agreed these were all breeches in proper infection control practice.	F 880	100% compliance is achieved on 3 consecutive evaluations, then monthly until 100% compliance is achieved on 5 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 87 Findings were reviewed with E1 (NHA), E2 (DON) and E3 at the exit conference on 5/23/18 at 11:45 AM.	F 880		

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

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(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center
May 23, 2018

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from May 14, 2018 to May 23, 2018. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 107. The Stage 2 sample totaled 47 (forty-seven) residents.	3310.1.2 Please see POC for F558, F565, F584, F623, F640, F655, F657, F684, F686, F689, F690, F692, F695, F697, F711, F725, F758, F761, F812, F867, F880.	
3201			
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		7/9/18
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed May 23, 2018: F558, F565, F584, F623, F640, F655, F657, F684, F686, F689,	A. No specific residents were cited. B. Current residents have the potential to be affected. C. The Scheduling Manager will staff the facility at or above minimum staffing requirements. The Facility Leadership will round daily to ensure that staffing is maintained at or above minimum staffing requirements. D. The Center Nurse Executive/designee will audit the HPPD (Attachment A) daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 5 consecutive reviews. Results of audits will be presented to the monthly QAPI committee meetings for review and recommendations.	

Provider's Signature Doris Schuhmann Title Administrator Date 6/22/18

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NAME OF FACILITY: Seaford Center **DATE SURVEY COMPLETED:**
May 23, 2018

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	F690, F692, F695, F697, F711, F725, F758, F761, F812, F867 and F880. 16 Del. C., 1162 Nursing Staffing: (c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. Nursing staff must be distributed in order to meet the following minimum weekly shift ratios: RN/LPN CNA* Day 1 nurse per 15 res. 1 aide per 8 res. Evening 1:23 1:10 Night 1:40 1:20 *or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. --- Three (3) weeks of facility staffing, covering the workweeks of:		

Provider's Signature Dana Schuhmann Title Administrator Date 6/22/18

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	18 through 24 February 2018, 29 April through 5 May 2018, 6 through 12 May 2018, were reviewed to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. The review consisted of data entered on the DLTCRP Staffing Worksheets by Seaford Center Staff and signed by the Administrator. The **One (1)** citation hereon results from that work. **The law was not met as evidenced by:** Seaford Center failed to meet the required 3.28 Daily Care Hours per Resident on Saturday 24 February 2018. The Care Hours per Resident attained by Seaford Center on 24 February 2018 were (3.25).		

Provider's Signature Doris Schoenbrunner Title Administrator Date 6/22/18

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STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center
May 23, 2018

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Provider's Signature Doris Achenbrunner Title Administrator Date 6/22/18

Attachment H

HPPD Audit

Date	Census	# of Staff Hours	HPPD	Corrective Action Needed?

Auditor ______________________________